

Facility Contact Information

*Tracking #: _____

Facility Information: _

*Facility Name: _____

*Main Telephone Number: () _____ - _____

*Mailing Address: _____

*City: _____ *County: _____ *State: _____ *ZIP: _____ - _____

For each identifier listed below, enter the # / code or check Not Applicable if your facility does not have that identifier:

*American Hospital Association ID #: _____ Not Applicable

*CMS Provider #: _____ Not Applicable

*VA Station Code: _____ Not Applicable

If none of the above identifiers is applicable, enter CDC-provided Enrollment #: _____

*Facility Type (indicate one from list): _____

*NHSN Components: Indicate which component(s) the Facility will use initially use (components may be added at any time after enrollment)

- Patient Safety Component
- Healthcare Personnel Safety Component

NHSN Facility Administrator:

*Name: _____

Title: _____

Mailing Address: (if different from facility) _____

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

*Telephone Number: () _____ - _____ Extension: _____

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

*Pager Number: () _____

*Email: _____ *A valid email account is required.*

*User Name: _____

NHSN Patient Safety Primary Contact Person (if different from Facility Administrator):

Name: _____

Title: _____

Mailing Address: (if different from facility)

City: _____ State: _____ ZIP: _____ - _____

Telephone Number: () _____ - _____ Extension: _____

FAX Number: () _____ - _____

Pager Number: () _____ - _____

Email: _____ *A valid email account is required.*

NHSN Healthcare Personnel Safety Primary Contact Person (if different from Facility Administrator):

Name: _____

Title: _____

Mailing Address: (if different from facility)

City: _____ State: _____ ZIP: _____ - _____

Telephone Number: () _____ - _____ Extension: _____

FAX Number: () _____ - _____

Pager Number: () _____ - _____

Email: _____ *A valid email account is required for enrollment.*

Microbiology Laboratory Director/Supervisor (if different from Facility Administrator):

Name: _____

Title: _____

Mailing Address: (if different from facility)

City: _____ State: _____ ZIP: _____ - _____

Telephone Number: () _____ - _____ Extension: _____

FAX Number: () _____ - _____

Pager Number: () _____ - _____

Email: _____ *A valid email account is required for enrollment.*